DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO THE DEATH OF MP

Forty-one year-old female patient dies at Western State Hospital after being found unresponsive in her bedroom on July 7, 1997.

DRVD CASE# 97-0350 M
Department For Rights of Virginians With Disabilities
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I. INTRODUCTION:

This is a summary of the findings of the investigation by the Department for Rights of Virginians with Disabilities (DRVD) into the death of MP, a 41 year-old female patient at Western State Hospital (WSH). On July 7, 1997, MP was found unresponsive in her bedroom at WSH at approximately 3:55 AM. MP was later pronounced dead at approximately 4:30 AM.

DRVD conducted this investigation of an alleged incident of abuse and/or neglect pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.).

The investigation included the following:

1. Review of MP's medical records at WSH;
2. Review of the University of Virginia (UVA) Medical Center's Provisional and Final Autopsy Reports;
3. Review of MP's UVA Medical Center's Discharge Summary, dated September 1994;
4. Review of MP's Certificate of Death;
5. Review of past correspondence between WSH and MP's immediate family members;
6. Interviews with members of MP's immediate family;
7. Interview with MP's brother's friend;
8. Interviews with MP's WSH Ward A4 roommates; and
9. Review of videotaped interview with MP's friend, a previous patient at WSH who was with MP the day before she died.

The investigation also included a review of the clinical records by a board-certified psychiatrist under contract to DRVD as a medical expert.

II. BACKGROUND:

A. The Facility

WSH, located in Staunton, Virginia, is a 424 bed psychiatric facility licensed and operated by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). The facility provides diagnosis and treatment of mental disorders for adults and is divided into various units for specific patient populations.

WSH is accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO). JCAHO conducted an on-site review of WSH in August 1997, and WSH was accredited with commendation on September 27, 1997. Following notification of this "critical incident," JCAHO completed an additional review of WSH in August 1998. WSH was accredited with recommendations for improvement on August 12, 1998.

The United States Department of Justice conducted an on-site assessment of WSH in Fall 1998. WSH is currently awaiting recommendations from this assessment.

B. The Patient

MP was a 41 year-old female patient who was transferred to WSH from Northern Virginia Mental Health Institute (NVMHI) in February 1991 for further care and treatment of her Schizoaffective Disorder. MP had seven previous admissions to NVMHI and three previous admissions to WSH.

Upon transfer to WSH, MP's medical record documents that she denied hallucinations but was delusional as evidenced by her telling staff that she had just run for U.S President. She denied homicidal or suicidal ideation, her judgment was poor, and her insight into her condition was minimal to absent. She was also described as obese with a weight of 218 pounds.

During the course of her hospitalization at WSH, MP's diagnosis was changed to Schizophrenia, Undifferentiated Type, Chronic Obstructive Pulmonary Disease (COPD), and Obesity. While at WSH, MP resided on various wards, with primary medical care provided by physicians employed by WSH.

III. CARE PROVIDED TO MP AT WSH

A. September 1994 to July 1996

In early September 1994, MP's WSH treatment team placed her on a pass to discharge to a group home in Arlington, Virginia. The day after MP left WSH on a pass to discharge, her brother, also her Authorized Representative at the time, contacted WSH and demanded that she be returned to WSH. Documentation reveals that WSH failed to involve MP's brother in the discharge planning process and also failed to adequately inform him that MP was being placed on a pass to discharge in the community. When MP returned to WSH the next day from the pass, she began experiencing shortness of breath and cough productive of green sputum. A chest x-ray suggested the probability of bronchial pneumonia. MP was taken to the WSH Medical Unit and treated with antibiotics as well as bronchodilators.

On September 11, 1994, while on the WSH Medical Unit, MP was found:

cyanotic with a respiratory rate of 40 and a pulse of 130 with mental status changes. She was taken to the local hospital and then transferred to the emergency room at the UVA Medical Center where she was then admitted for an acute exacerbation of her COPD, secondary to tobacco abuse, and required intubation for respiratory failure. When MP returned to WSH from this hospitalization on September 23, 1994, she was placed on a no-smoking regimen. However, WSH staff documented in her record that monitoring her smoking was difficult because she spent much time away from her ward and out of the staff's view.

MP's record documents that from September 1994 to July 1996 she remained obese despite her attempts to diet. Although her maximum weight increased only a total of four pounds during this period, her weight fluctuated from 233 pounds in October 1994 to 251 pounds in May 1996 then down to 237 pounds in July 1996.

From September 1994 to July 1996 MP had no further exacerbations of her COPD. During this period MP denied cigarette smoking but was observed by staff obtaining cigarettes from other residents and visitors.

B. July 1996 to May 1997

MP's medical record documents that in July 1996 MP agreed to a six-month trial of Clozapine (Clozaril), an atypical antipsychotic. MP's

physician hoped that Clozapine might have a favorable impact on MP's disorganization and delusional ideation. A Physician's Progress Note dated July 24, 1996 documents that MP's physician discussed the use of Clozapine with her and that "she asked the appropriate questions about white blood count problems and seizures, and understands the other lesser side effects."

The Physician's Progress Note also documents that MP's physician discussed the use of Clozapine with MP's sister, who had recently been named as MP's new Authorized Representative. MP's physician noted that "I have also discussed the situation with her sister (AR), who is in agreement. We will send her a basic description of the medication as well." There is no documentation that he fully discussed the risks and benefits associated with the use of Clozapine with her.

The medical record documents that MP made the following contract with her physician at that time: "she will agree to a 6 month trial of Clozaril on CSU (Clinical Studies Unit) and should she be unhappy with its use at the end of 6 months it will be discontinued in favor of another antipsychotic." MP was transferred to CSU in late July 1996 to begin Clozapine. MP's weight at the time she began Clozapine, in July 1996, was documented as 237 pounds.

During October 1996, MP's sister contacted MP's physician and reported her concerns regarding MP's risk for cardiac events while on the Clozapine and requested a medical consultation. As a result, MP's physician obtained a medical consultation from the internist who worked on the Medical Acute Care Unit at WSH. The internist who completed MP's medical consultation, dated November 20, 1996, concluded that:

MP had demonstrated mild intermittent tachycardia as the only "cardiac" side effect to Clozaril to date. While her weight gain is significant and temporally related to Clozaril she clearly suffered from significant obesity prior to institution of the drug. She is very determined to continue Clozaril and increase her dose as needed because of her desire to become well enough to leave the hospital.

Her risk for cardiac disease is above average based on the risk factors outlined above, however her age and sex and lack of significant past history or other major risk factors such as smoking or hypertension (recent mild increase in blood pressure aside) are favorable in her regard.

Potential benefits of Clozaril in this patient outweigh poorly defined cardiac risks from Clozaril. Fasting lipid profile (12-16 hour fast), rigorous attention to diet and exercise and continued follow-up of blood pressure are important general health issues.

No pulmonary function testing was recommended as a result of this consultation. No follow-up was evidenced in MP's medical record by the internist after this consultation. MP's weight in October 1996 was documented as 254 pounds.

In December 1996 MP's physician documented in her medical record that she had experienced little or no benefit from the Clozapine, except for some noted improvement in her disorganization. She had shown a decline in functioning, particularly her daily living skills, and a marked increase in weight, with possible exacerbation of pulmonary problems, hypersalivation, and amotivation. He noted that MP denied smoking and that she was experiencing "gnawing" epigastric pain at night consistent with upper GI reflux. MP's physician documented that he planned to slowly lower her Clozapine to aid the adverse effects she was experiencing and possible try another antipsychotic drug, Olanzepine. MP's medical record indicates that she refused to be weighed in December 1996.

MP's physician documented that he met with MP in December 1996 to discuss the Clozapine and that he had also "talked at some length to her sister," who was her Authorized Representative. There was no further documentation of the date and time of this conversation and what matters were discussed with the Authorized Representative.

On January 3, 1997, following her return from a Christmas pass to her brother's home in Oklahoma, MP told her physician that her brother thought she was doing better on Clozapine. As a result, MP's physician decided to decrease the Clozapine just enough to aid the adverse effects. There was no documentation in the medical record that MP's physician discussed this with MP's sister, who was her Authorized Representative.

In April 1997 MP continued to be on Clozapine. Her physician noted in her record that she was better organized while on a low dose of Clozapine, but continued to experience amotivation. MP's weight in April 1997 was documented as 266 ½ pounds.

On May 21, 1997 MP's physician documented that "I have finally convinced MP to a trial of Sertraline after multiple discussions." The Sertraline was started on May 22, 1997 in addition to her Clozapine. There

is no documentation in MP's medical record that her physician discussed the addition of Sertraline with her sister, who was her Authorized Representative, or obtained informed consent from her Authorized Representative prior to starting MP on Sertraline. The record did note that MP's physician discussed the addition of Sertraline with MP's brother in Oklahoma, who was not the Authorized Representative. MP's weight on May 31, 1997 was documented as 266 ½ pounds.

B. June 1997 to July 1997

A WSH Nursing Note dated June 10, 1997 documents that MP told nursing staff that she vomited beside her bed during the night and could not get up in time to make it to the bathroom. No medical follow up was noted to have occurred.

On June 19, 1997 MP was transferred to WSH's Psychosocial Rehabilitation Unit, Ward A4 as a result of census issues on CSU. MP's transfer note, dated June 18, 1997 and completed by the CSU physician, stated that there had been little overt change in MP as a result of the addition of Sertraline and that her behavioral plans addressing weight gain and amotivation thus far had been ineffective. He recommended continuance of a low dose of Clozapine with the possibility of a trial of the antipsychotic drug, Olanzepine. Careful monitoring of MP's smoking due to her respiratory disease was also recommended. MP's weight upon transfer to Ward A4 was documented to be 266 ¼ pounds.

MP met with the Ward A4 physician on June 19, 1997. During this meeting MP complained to the physician that she did not believe that Sertraline had helped her and that it made her constipated. She admitted to the physician that she smoked approximately four cigarettes a day and expressed an interest in using nicorette gum. The physician documented that he would continue MP's present medications for a short period of time, continue her present privilege level, and facilitate her adjustment to the ward.

A WSH Nursing Note dated June 28, 1997 documents that MP vomited her lunch beside her bed. Staff noted that MP had eaten her lunch "very hurriedly" and ate more than one tray of food. Nursing staff gave MP a broom/pan to clean the vomitus herself. No medical follow up was noted to have occurred.

A Treatment Planning Conference Note dated June 30, 1997 documents that MP met with the members of her treatment team and told them that she

did not feel well on Clozapine and Sertraline. It was noted that she was particularly upset about the Clozapine causing a great weight gain. The record reflects that MP's physician was to "evaluate medications, but slowly."

A Physician's Progress Note dated June 30, 1997 documents that MP's physician met with her and again declined to make changes in her medications at that time because MP needed to settle in on her new ward and he needed to become familiar with her level of functioning. There is no documentation in MP's medical record that these matters were discussed with her Authorized Representative following her transfer to Ward A4. MP's last documented weight in July 1997 was 274 pounds.

MP's WSH medication record reflects that she was continued on the following medications on Ward A4:

Clozapine (Antipsychotic) 75 mg. qhs and 50 mg.q4pm
Sertraline (Antidepressant) 50 mg. bid
Cogentin (Side Effects) .5 mg. qhs
Vancenase AQ (Nasal Conditions) 2 puffs both nostrils qid
Theophylline (Wheezing, Shortness of Breath) 400 mg. Bid

IV. CIRCUMSTANCES SURROUNDING MP'S DEATH

A. Review of WSH Medical Record

On July 3, 1997, a Social Work Note documents a telephone conversation between MP's sister, who was her Authorized Representative, and MP's WSH social worker. MP's sister called to report that MP had called her brother's friend the night before, complaining that she "felt like she was dying." MP's sister expressed concern about MP's heavy breathing and obesity and requested a full medical work-up for MP. MP's WSH social worker told MP's sister that she would request that the Nurse Practitioner schedule MP for a full physical to initiate her request. This was the last documented entry in MP's medical record until she was found unresponsive in her bedroom on July 7, 1997. There is no documentation in MP's medical record regarding any follow up to MP's sister's request for a full medical work-up.

In a telephonic interview with DRVD's medical expert on July 27, 1998, MP's physician stated that:

He saw MP on Thursday July 3, 1997. He inquired about her physical symptoms. She told him that she did not like the ward and that the rules against smoking were harsher on this new ward. She complained that Clozaril was making her fat. He stated that he did not want to change her medications at that time because he wanted to get to observe her more. He stated that she had no physical complaints. MP's physician regretted not writing down this interaction in the medical record. He also stated that he was assigned too many patients and that there was not enough time to get to know them.

A WSH Nursing Note completed by the Registered Nurse who found MP and dated July 7, 1997 states:

Checked at 0355 during routine ward check. Snoring lightly but laying side-ways in bed. Undersigned went for help to awaken and turn pt. in the bed. When staff returned to the room her name was called and shoulder was patted to awaken pt. Staff noted pt. had saliva around mouth. Pt. was lifted from the bed and placed on floor. CPR initiated immediately, 911 called for OD (Doctor on Call) and extra help. (Prior to being layed on floor no pulse was found.) CPR initiated @ approx. 0400. OD to ward @ approx. 0410. Staunton Augusta Rescue Squad to ward @ approx. 0417. CPR called off by OD 0430. Medical Examiner called by OD. Unable to reestablish pulse and breathing in pt. Pt.'s sister notified of pt.'s death by OD.

A WSH Nursing Note Late Entry completed by the Registered Nurse on July 7, 1997 states:

When pt. was called and touched to awaken, her skin was warm and dry. Skin of normal skin tone. Limbs movable. Lifted from bed by RN holding one wrist in each hand, HCSW (Human Services Care Worker) lifted pt. @ hips, lowered to floor gently by staff. CPR initiated. After 5 mins. (approx.) of CPR no apical pulse found with stethoscope. Both roommates left the rm. Promptly at beginning of CPR.

A WSH Physician's Progress note completed by the WSH OD on July 7, 1997 states:

Called by information desk at 4:04 AM calling to A-4 emergency. I arrived at 4:10 AM and pt. was undergoing CPR by correct method (two person). Airway was cleared with suction and pt. had air moved into lungs by pulmonary exam. An attempt was made by myself to place an I.V. access in left forearm unsuccessfully. Pt. with obese habitus. Prior h/o resp.

arrest. Rescue Squad arrived at 4:15 AM. and took over CPR. Defibrillation not indicated by monitor (semi-automatic defib.) CPR continued unsuccessfully and code was called at 0430. Rescue squad continued with CPR and attempted trach-tube in addition to monitored pt. with defibrillator. WSH Administrator on Call (AOC) notified at 4:35 AM. Medical Examiner called, who felt, by history, that this was natural causes (likely cardiopulmonary event) and Medical Examiner involvement not indicated. By history, the pt. suffered from COPD, obesity, and prior h/o respiratory arrest 9/94. No evidence of acute physical symptoms noted in the chart over past 2 wks. Likely cardiopulmonary event. Called sister, at 0515. She was with family and will notify them. Will place pt. in WSH morgue.

B. Information from MP's Immediate Family

In December 1996, MP visited with her brother in Northern Virginia after returning from a pass with family in Oklahoma. MP's brother believed that MP's physical status was poor as evidenced by her significant weight gain, lack of motor coordination, tremors, and shortness of breath.

In April 1997, MP visited her sister for five days in Northern Virginia. The sister described MP as coherent during the visit, but that she continued to have a significant weight problem and made constant gurgling sounds due to her shortness of breath. MP's sister reported that after this pass, MP began calling her less frequently than usual. MP's sister said that she was contacted by MP's WSH social worker and told that MP's behavior had become increasingly erratic. MP's sister said that WSH staff suspected that MP had obtained and taken diet pills from another patient and that this accounted for the change in her behavior. There is no documentation in MP's medical record of a telephone call from MP's WSH social worker to MP's sister regarding MP's erratic behavior or that WSH suspected that MP had taken diet pills belonging to another patient.

On June 19, 1997, the day MP was transferred to WSH Ward A4, MP telephoned her brother in Northern Virginia and told him that she had been transferred to Ward A4 because "the CSU physician did not want her death on his hands."

On July 2, 1997, MP telephoned her brother's home and spoke with his friend, who is a Registered Nurse and a reserve Lieutenant Colonel in the Army Nurse Corps. MP's first words were "I'm dying." MP then began to discuss her weight gain up to 280 pounds and her children. She asked if her brother could come to WSH and take over as her Authorized Representative

and be involved in her treatment. The brother's friend noted that during this conversation, as well as others during the last several months, that MP was wheezing, exhibiting shortness of breath, and "sounded terrible." The brother's friend immediately contacted MP's sister to report this to her, since she was MP's current Authorized Representative.

On July 3, 1997, MP's sister contacted MP's WSH social worker and reported MP's telephone call to her brother's friend the night before stating that she "felt as if she were dying." MP's WSH social worker said that MP's behavior was paranoia. MP's sister requested a full medical work-up but was told by MP's WSH social worker that the soonest it could be done would be on July 7, 1997 due to the long holiday weekend.

C. Information from Other WSH Patients

A WSH patient who was also a close friend of MP's, reported that on July 6, 1997 MP was having a great deal of difficulty breathing while sitting outside on the steps to her ward. MP's friend attempted to obtain her inhaler for her due to MP's shortness of breath and inability to walk up the ward steps. The staff refused to give MP's inhaler to the friend. MP's medication record confirms that she did not receive her 12 PM (noon) dose of her Vancenase AQ inhaler on July 6, 1997. There is no documentation in MP's medical record as to this incident or the reason why she did not receive her medication on this date and time.

MP's roommates reported that she had a severe breathing problem and would gurgle and snore loudly night. They would at times awaken MP so that she would stop gurgling and snoring. The roommates also reported that on several occasions, including the night of July 6, 1997, MP would tell them at bedtime that she felt like she was "going to die."

One of MP's roommates reported that she was awakened on July 7, 1997, sometime between 3:00 AM and 5:00 AM, by MP's gurgling, but noticed that the sounds were different than usual. The roommate could hear MP gurgle then she seemed to stop breathing. The roommate was concerned and went to the Ward A4 nursing station and reported this to the Registered Nurse on duty. The Registered Nurse walked to MP's bedroom with the roommate and found MP to be unresponsive. The Registered Nurse then called for staff assistance and immediately began CPR. Both roommates were escorted by staff to another bedroom once CPR was initiated.

D. Other Documentation

The Staunton Augusta Rescue Squad call sheet dated July 7, 1997 documents that emergency personnel arrived on WSH Ward A4 at approximately 4:18 AM and found MP undergoing CPR in progress by WSH staff. The call sheet notes that MP's tongue was swollen and very large but there was no mention of her airway being obstructed. Rescue Squad personnel suctioned MP's nasal and trachea areas but CPR via airway was ineffective.

V. INVESTIGATIONS

A. Medical Examiner

The WSH OD (Doctor on Call) contacted the Medical Examiner at approximately 4:35 AM to report MP's death. The Medical Examiner did not believe that his involvement was warranted because of MP's history of obesity, respiratory arrest and COPD. The Medical Examiner told the OD during this telephone conversation that he believed her death was due to natural causes and that it was most likely the result of a cardiopulmonary event.

B. Report of Autopsy

MP's death certificate, dated July 7, 1997 and prepared by the WSH OD, listed the cause of death as "unknown." A second death certificate, dated July 29, 1997 and prepared by the WSH OD, listed the cause of death as undetermined, autopsy pending.

The final autopsy report completed by the University of Virginia, Health Sciences Center, Department of Pathology, dated October 29, 1997, determined the cause of death to be "Coronary Insufficiency due to Coronary Atherosclerosis and Cardiomegaly due to Hypertension." The autopsy report states:

Moderate atherosclerosis was found in the aorta and coronary arteries. No acute coronary thrombi are seen. Cardiomegaly with left ventricular hypotrophy suggests hypertension. The lungs show evidence of chronic heart failure with pulmonary edema and pleural effusions suggesting acute congestive failure.

The "Summary and Comments" section of the autopsy indicated that MP "died suddenly on July 7, 1997" and that "No acute physical symptoms

were noted in the two weeks prior to her death." This contradicts MP's WSH medical record which documents that MP as well as her family informed nursing and medical staff that she was not feeling well on her present medications and that she that felt as if she were dying.

VI. FINDINGS AND CONCLUSIONS

Based upon this investigation, DRVD finds that MP's death resulted, in substantial part, from a failure of WSH staff to recognize the significance of MP's physical complaints and from a failure of WSH staff to act in a timely fashion to evaluate these complaints.

DRVD's detailed findings are as follows:

1. WSH failed to acknowledge MP's significant past history of cardio-pulmonary pathology and provide appropriate follow-up.

   Following MP's 1994 hospitalization there was no cardiopulmonary follow-up until a medical consultation was requested by MP's sister, who was her Authorized Representative, in October 1996 due to her concerns regarding MP's risk for cardiac events while on Clozapine. The consultation completed in November 1996 noted that "the potential benefits of Clozaril in this patient outweigh poorly defined cardiac risks from Clozaril." No pulmonary function testing was recommended and no definitive cardiac and pulmonary diagnostic testing was completed to effectively assess the cardiopulmonary risks in this patient. This consultation also discounted smoking as a risk factor, however it was generally acknowledged by WSH staff that MP continued to smoke throughout her hospitalization. Upon her transfer to Ward A4 on June 19, 1997 MP admitted to her physician that she smoked approximately four cigarettes a day.

   WSH staff also failed to respond to relevant communications from MP and her family concerning her physical health. On June 30, 1997 MP reported to staff that she did not feel well on the Clozapine and Sertraline, but staff declined to make any changes in her medications or evaluate her physical status. On July 3, 1997 MP's family contacted WSH staff to report that MP had called the family the night before to report that "she was dying." MP's sister requested an immediate medical work-up but was told by WSH staff that this could not be done until July 7, 1997 due to the long holiday weekend. MP's medical chart for the last four days of her life is completely blank except for this documented phone call from family.

WSH staff failed to modify MP's medication regimen in a timely fashion in response to MP's worsening physical status and significant side-effects. MP was told in July 1996 that at the end of a six-month trial of Clozapine, she could have it discontinued if she was not happy with the results. She requested that the Clozapine be discontinued in December 1996, but this never occurred. As a result, MP continued to gain weight and her breathing became increasingly labored. MP also told her WSH treatment team and physician that she did not feel well on the Clozapine and Sertraline, but her physician declined to make any changes in her medications.

2. WSH failed to regularly consult with MP's Authorized Representative regarding medication and treatment decisions or to obtain informed consent from the Authorized Representative regarding the administration of medications.

   WSH Hospital Instruction Number 4030 – Patient's Participation in Treatment Decision-Making and Informed Consent for Treatment, requires the appointment of an Authorized Representative when a patient lacks the capacity to make an informed decision regarding the risks and benefits of the proposed treatment. The instruction further requires that after the Authorized Representative has been appointed, informed consent shall be obtained from the Authorized Representative for any treatment or course of treatment that presents significant risk to the patient.

   MP's physician noted in July 1996 that he had discussed the use of Clozapine with MP's sister and that she was in agreement. However, there is no documentation in the medical record that the risks and benefits of Clozapine were clearly defined for MP's sister, before she gave her consent. The medical record indicates that a basic description of the medication was to have been sent to MP's sister, but there is no documentation that this occurred.

   There is no evidence in the medical record that MP's Authorized Representative was consulted by MP's physician in December 1996 before he decided to only lower her Clozapine to reduce her reported side effects, despite MP's request that this medication be discontinued.

   There is no evidence in the medical record that MP's Authorized Representative was consulted by MP's physician in May 1997 regarding the addition of Sertraline to MP's medication regimen.

There is no evidence in the medical record that MP's Authorized Representative was consulted by MP's physician to discuss treatment decisions at any time following her transfer to Ward A4 in June 1997.

3. WSH failed to involve MP's Authorized Representative in the discharge planning process and also failed to adequately notify MP's Authorized Representative that MP was being placed on a pass to discharge to the community in September 1994. MP's brother, who was her Authorized Representative in September 1994, had not been actively engaged in MP's discharge planning process by WSH, and was not informed that MP had been placed on a pass to discharge by WSH until after the fact.

   There is no evidence in the medical record that MP's Authorized Representative was consulted before the decision was made in September 1994 to place her on a pass to discharge to a group home in Arlington, Virginia.

VII. RECOMMENDATIONS

The following recommendations are suggested based upon the above findings and conclusions:

1. WSH shall ensure that all patient physical complaints are immediately documented in the medical record and evaluated in a timely and comprehensive manner.

2. DMHMRSAS Office of Human Rights shall ensure more intensive training for clinical staff at all DMHMRSAS facilities regarding the Authorized Representative process and informed consent issues during initial orientation and at least annually thereafter.

3. WSH shall ensure the participation of the Authorized Representative in the discharge planning process, including recommendations for placement and treatment in the community.

4. WSH shall require documentation in the medical record by the physician, of all discussions with Authorized Representatives regarding consent to medications and treatment, which shall fully document the risks and benefits of the medications to be prescribed and the Authorized Representative's informed consent.

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